erasing diabetes
winning without meds

Registration Form

You may skip over shaded areas.

Name		**Age**	**Today's date**
Address		**Phone**	**Year diagnosed**
Email address		**Occupation**	**Date of birth**
Weight	**BMI**	**Doctor who manages your diabetes/prediabetes**	**Last visit**
Height	**HbA1c**		

What level of schooling have you completed?

□Elementary □High school diploma □Some college □College degree
□Graduate school □Military training □Technical/vocational/business

How would you rate your understanding of diabetes/prediabetes?

□Excellent □Good □Average □Minimal

Which of the following describes the way you feel about having diabetes/prediabetes?

□Okay □Scared □Loss of control □Nuisance □Depressed □Anxious □Hopeless

What areas of diabetes would you like to learn more about? (check all that apply)

□ Diabetes overview/how the disease begins and progresses
□ Diet/weight loss/impact on blood sugar levels
□ Medications
□ Physical activity/impact on blood sugar levels
□ Monitoring of blood glucose
□ Complications of diabetes (prevent/detect/treatment)
□ Behavior changes/goal setting
□ Other

What is your diabetes/prediabetes-related goal?

Preferred method of learning (check all that apply) □Listening □Reading □Observing □ Doing

Do you believe that you can control your health? □Mostly □Sometimes □No

Many people have been able to normalize blood sugar with diet and exercise. Would you like to learn more about this? □Yes □No

Ethnicity

□Caucasian □African American □Hispanic □Native American □Asian □Middle Eastern

Do you have any cultural or religious practices or beliefs that influence the way that you care for your diabetes/prediabetes? □Yes □No If yes, please describe.

Difficulty with

□Hearing □Seeing □Reading □Speaking □Physical □Psychological □English □None
Please explain:

How confident are you filling out medical forms by yourself?

□ I don't have a problem □Sometimes I need help □ I need help

Is it difficult to afford the food, medications, and other things that you need to care for yourself? □No □Sometimes □ Frequently Please explain:	
From whom do you get support for your diabetes/prediabetes? (check all that apply) □Family □Co-workers □Healthcare providers □Support group □No one	
Smoker status □ Current □ Quit □Never	**Do you drink alcohol?** □Yes □No If yes, please describe.
Do you have a stressful lifestyle? □Yes □No If yes, please describe.	
When was your last (mo/yr) dental exam _____ eye exam _____ foot exam _____ flu shot _____	
How ready are you to put the effort into losing weight? □Not at all □I'm thinking about it □I'm ready for it □I'm already doing it □Weight is not a concern	
How ready are you to put the effort into monitoring your blood sugar levels with a glucometer? □Not at all □I'm thinking about it □I'm ready for it □I'm already doing it	
How ready are you to put the effort into exercising? □Not at all □I'm thinking about it □I'm ready for it □I'm already doing it	
Do you have any limitations to exercise? □Yes □No If yes, please describe.	
How would you describe your overall health? □Excellent □Good □Fair □Poor	**Do you feel rested when you wake up?** □Yes □No
List any health conditions that you **are currently being treated for,** e.g. high cholesterol, high blood pressure, cancer, hernia, thyroid, auto-immune, etc.	
List any health conditions that you **have been treated for in the past**, e.g. high cholesterol, high blood pressure, cancer, hernia, thyroid, auto-immune, etc.	
Please list any medications that you take including prescription, over-the-counter, herbal remedies, and vitamins (you may attach a separate list)	
Medication name Dose/frequency	Medication name Dose/frequency
1.	5.
2.	6.
3.	7.
4.	8.
Do you test your blood sugar? □ Yes □ No □ I don't have a glucometer I test _____ times a day.	**Do you have (drug, food, environmental) allergies? Please explain.**
Average results (range from low to high)	**Has having diabetes affected your romantic relationship in anyway?** □Yes □No Would you like guidance for seeking help? □Yes □No
Do you have pain in your muscles when you walk/exercise?	**Have you had previous diabetes education?** □Yes □No Year _____

Thank you for filling out this form. The information will help us to create the best diabetes program for you.

You may bring your spouse, another family member, or a friend with you to the meetings.